State of Hawai‘i
DEPARTMENT OF PUBLIC SAFETY

CRIME VICTIM COMPENSATION COMMISSION

The Crime Victim Compensation Commission was established on July 1, 1967 and is governed by Chapter 351, Hawai‘i Revised Statutes. The Commission helps victims with crime-related costs. Funding sources include fees from offenders, inmate wages, federal grant funds, and reimbursement from restitution payments.

Who can get help?

You can get help if you were involved in a covered crime* that occurred in the jurisdiction of Hawai‘i and you are:

- A victim who suffered injury.
- A person responsible for the maintenance of the victim who has suffered monetary loss because of the victim’s death or injury.
- A person engaged in business or educational activity at the scene of a mass casualty (mental health counseling expenses only).
- A relative of a deceased victim who has incurred medical or funeral expenses as the result of the victim’s death or injury.
- A dependent of a deceased victim.
- A Hawai‘i resident who is a victim of an act of international terrorism.

*** Covered Crimes**

- Murder
- Manslaughter
- Negligent Homicide I and II
- Negligent Injury I and II
- Assault I – III
- Sexual Assault I – IV
- Kidnapping
- Abuse of Family and Household Member
- International Terrorism

If I am eligible, what benefits do I get?

You **may** receive compensation for:

- Medical and mental health counseling expenses that are not covered by other sources.
- Lost earnings or support that is not covered by other sources.
- Funeral and burial expenses that are not covered by other sources.
- Acknowledgement award for victims only. Acknowledgement awards are symbolic in nature and are awarded to acknowledge a victim’s suffering, rather than to compensate for that suffering. Such awards are not intended to quantify physical/emotional losses suffered as a result of the crime and are based on the facts and circumstances of the crime and the severity of the criminal offense. The maximum acknowledgement award is $400, subject to change at any time, based on the availability of funding.
- Pecuniary loss directly resulting from the injury or death of the victim.
- Property damage (“Good Samaritans” only).

No compensation will be awarded for lost property, telephone bills, copying costs, meals, parking, fees for late charges or filing fees.

The Commission is a payor of last resort. The Commission may pay compensation only after all other sources have been exhausted. An award may be reduced by amounts received from Workers’ Compensation, Motor Vehicle Insurance, Civil Suits, Temporary Disability Insurance or Restitution from the offender. You must file timely claims with Workers’ Compensation, Motor Vehicle Insurance, Temporary Disability Insurance and your medical insurance carrier. You must reimburse the Commission if you receive moneys from these sources.

How do I apply?

- You must report the crime to law enforcement officials (police, naval investigative service, military police or Federal Bureau of Investigation) without undue delay.
- You must file an application with the Commission within 18 months of the crime date. Late applications will be accepted upon a showing of good cause.

You are responsible for….

1. Completely filling out and submitting the following:
   - A signed *Application Form* (Form #1).
   - A signed *Authorization to Release Medical/Mental Health Treatment Information Form* for each treatment provider (Form #2).
   - Proof to substantiate your claim (bills, receipts, insurance statements, and medical records).
2. If you are making a claim for lost wages:
   - Completely filling out and signing the *Authorization to Release Employment Information Form* and submitting it to your employer (Form #3).
   - Submitting proof to substantiate your claim for lost wages (pay stubs, Income Tax returns if self-employed, and a medical disability certificate) to the Commission.
3. If you were assaulted in a Motor Vehicle or injured as the result of a Motor Vehicle collision:
   - Contact your No-Fault Insurance provider and request that they cover your crime-related expenses.

What to expect from the Commission

- The Commission will attempt to secure law enforcement reports. This may take up to 2 months.
- You will receive a written decision and order either awarding compensation or denying your application.

Need more help? Contact the following:

Department of Public Safety, State of Hawai‘i
Crime Victim Compensation Commission (CVCC)
1136 Union Mall, Suite 600
Honolulu, Hawai‘i 96813
Phone: (808) 587-1143
Fax: (808) 587-1146
Web Page: http://www.hawaii.gov/cvcc
Neighbor Islands Toll Free:

- Hawai‘i County 974-4000, x71143
- Kaua‘i County 274-3141, x71143
- Maui County 984-2400, x71143
- Moloka‘i/Lāna‘i 1-800-468-4644, x71143

City & County of Honolulu
Department of the Prosecuting Attorney
Victim Witness Kokua Services
1060 Richards Street, 9th Floor
Honolulu, Hawai‘i 96813
Phone: (808) 768-7401
Fax: (808) 768-6417
Toll Free: 1-800-531-5538
Hearing Impaired: (808) 768-7404

Mothers Against Drunk Driving (MADD)
745 Fort Street Mall, Suite 303
Honolulu, Hawai‘i 96813
Phone: (808) 532-6232
Fax: (808) 532-6004
Neighbor Islands Toll Free: 1-800-578-6233
Web Page: http://madd.org/hi
Email: hi.state@madd.org

County of Hawai‘i
Office of the Prosecuting Attorney
Victim Witness Assistance Program
655 Kīlauea Avenue
Hilo, Hawai‘i 96720
Phone: (808) 934-3306
Fax: (808) 934-3517

West Hawai‘i:
81-980 Haleki‘i Street, Suite 150
Kealakekua, Hawai‘i 96750
Phone: (808) 322-2552
Fax: (808) 322-6584

County of Kaua‘i
Office of the Prosecuting Attorney
Victim Witness Program
3990 Ka‘ana Street, Suite 210
Līhu‘e, Hawai‘i 96766
Phone: (808) 241-1888
Fax: (808) 241-1757

County of Maui
Department of the Prosecuting Attorney
Victim Witness Assistance Division
150 South High Street
Wailuku, Hawai‘i 96793
Phone: (808) 270-7695
Fax: (808) 270-6188

Department of Public Safety – State of Hawai'i
Crime Victim Compensation Commission

FORM #1

APPLICATION FORM

For Office Use Only – Case #:	Crime Victim Compensation Commission State of Hawai'i, Department of Public Safety 1136 Union Mall, Room 600 Honolulu, Hawai'i 96813 Telephone: (808) 587-1143 Fax (808) 587-1146 Website: http://www.hawaii.gov/cvcc E-mail: cvcc@hawaii.rr.com
***TYPE** or **PRINT** in Black or Blue ink. Provide as much information as possible.*	

VICTIM INFORMATION

Name_____ Home Phone: _____
First Middle Last Cell/Pager: _____

Mailing Address _____ Work Phone: _____
Street City State Zip

Date of Birth ___ ___/___ ___/___ ___ ___ ___ Social Security No. ___ ___ ___-___ ___-___ ___ ___ ___

PLEASE CHECK:

Sex □ Male □ Female **Disabled** □ Yes □ No

Marital Status □ Married □ Single **Were you visiting Hawai'i at the time of the incident?** □ Yes □ No

Check the one you believe represents your ethnicity:

□ Black □ Chinese □ Filipino □ Hawaiian □ Portuguese □ Hispanic □ Other
□ Samoan □ Japanese □ Korean □ White □ Puerto Rican □ Native American

APPLICANT INFORMATION (Complete **only if** you are applying for a Victim who is a minor, deceased, or is incapacitated.)

Applicant's relationship to victim: _____ Home Phone: _____
Cell/Pager: _____
Work Phone: _____

Name_____
First Middle Last

Mailing Address _____
Street City State Zip

CRIME INFORMATION

Date of Crime _____ Type of Crime: (Assault, Sexual Assault, etc.) _____

Name of Suspect _____ Location of Crime _____
Last First Middle Street City Zip

Police Report No. _____

If incident was investigated by military police, provide the military police report no. and branch of service. _____

MEDICAL INFORMATION

Be sure to complete a Medical Authorization Form for each provider (doctor, hospital, or therapist) you saw due to the incident. In cases of death, provide the name of the mortuary or cemetery. Attach all bills, receipts, and insurance statements.

Name of Provider	**Address**	**Service Date**	**Total Charges**
1.			
2.			
3.			

Medical Insurance: Member #:

CONTINUED ON BACK

VICTIM EMPLOYMENT INFORMATION Complete only if claiming for Lost Wages

Did injury occur at work place? □ Yes □ No Did you miss work as a result of the injury? □ Yes □ No

Period of Absence: From _____ To _____
Month Day Year Month Day Year

Employer's Name_____ Phone No. _____

Mailing Address _____
Street City State Zip

Job Title: _____ Rate of Pay: _____

INSURANCE / LEGAL INFORMATION

Check all potential sources of full or partial payment of expenses:

□ Medical Insurance □ Motor Vehicle Insurance □ Homeowner's Insurance □ Social Security Disability
□ Welfare □ Medicare □ Medicaid □ Temporary Disability
□ Worker's Compensation □ Other (Specify) _____

Have you filed or do you intend to file a civil law suit? □ Yes □ No

- If Yes, please complete the following:

Attorney's Name _____ Telephone No. _____

Mailing Address _____
Street City State Zip

HOW DID YOU FIND OUT ABOUT THE COMMISSION Please check:

□ Hospital/Medical Personnel □ Sex Assault Counselor □ Police □ Newspaper □ Television
□ Prosecutor's Victim Witness □ Domestic Violence Counselor □ Radio □ Other (Specify) _____

Name of Referring Victim Witness Advocate: _____

VICTIM CERTIFICATION & SIGNATURE

I certify that I have read this application and have provided information that is true and correct to the best of my knowledge. I understand that the law provides for penalties for false statements. I will repay the Commission should I receive moneys from civil suits, restitution, or insurance payments.

Signature of Victim Date Signature of Applicant Date

STATEMENT OF POLICY: It is the policy of the Department of Public Safety, Crime Victim Compensation Commission, that no person shall on the grounds of race, color, religion, sex, national origin, age, or handicap, be excluded from participation in or subjected to discrimination when making their claim for compensation.

PLEASE CHECK BEFORE MAILING:

□ Have you signed the *Application Form?*
□ Have you provided us with your complete mailing address and telephone number(s)?
□ Have you completed the information regarding the Police Report Number, Crime Date, and Type of Crime?
□ Have you signed and submitted a *Medical Authorization Form* for each provider (doctor, hospital, clinic) that treated you?
□ Have you submitted all of your medical bills, funeral bills, insurance statements and receipts?
□ IF CLAIMING LOST WAGES, have you signed the *Employer Authorization Form* and submitted it to your employer?
  □ Have you submitted your pay stubs for the two periods prior to the incident and your medical disability certificate?
  □ If you are self-employed, have you submitted copies of your last two years' Federal and State tax returns?
□ IF incident occurred in a MOTOR VEHICLE, have you contacted your motor vehicle insurance company?

STATE OF HAWAIʻI
CRIME VICTIM COMPENSATION COMMISSION
1136 Union Mall, Room 600
Honolulu, Hawaiʻi 96813
Telephone: 808 587-1143
FAX 808 587-1146

FORM #2

I, _____ (____/____/____) authorize the release of protected health information from:
(name of patient) (Date of Birth)

Hospital/Doctor Name: _____

Hospital/Doctor Address: _____

_____

This information is required to process a claim with the Crime Victim Compensation Commission.

The Crime Victim Compensation Commission (Commission), requests all protected medical records and reports (x-rays not required) and an itemized statement of expenses, including any insurance payments, provider adjustments and/or patient payments

for the period: ___/____/____ to present.
(Date of Crime)

Specifically, the Commission also requests:

- Substance abuse treatment records
- Mental Health treatment records
- Sexually transmitted diseases including AIDS and HIV

The Commission releases the above named provider, its employees, agents, and staff physicians from all liability and all claims of any nature pertaining to the disclosure of information described above. This information is solely for use in the Commission's determination of eligibility for payment of your services and will not be re-disclosed to third parties.

The requested records are required to substantiate treatment and charges. The Commission will not pay for documents/copying fees. Federal Public Law 103-322 (H.R. 3355) Section 230202, provides that the Commission should be considered last payor and not a third party liability. Therefore, all insurance claims should be filed accordingly. If the insurance carrier denied the claim, please submit the denial document.

Authorization by the signatory is voluntary and may be revoked at any time upon receipt of written notice. Additionally, the service provider will not use this form to set as conditions for treatment, payment, enrollment, or eligibility for benefits except as allowed under federal privacy laws for: 1) research-related treatment, 2) health care provided solely for disclosure to a third party, or 3) health plan initial enrollment/eligibility determinations, underwriting, or risk rating determinations.

Patient Name: _____ Relation to Patient: _____
(or legal guardian if Patient is a minor or incapacitated)

Signature of Patient/Legal Guardian: _____ Date: _____

Legal authorization to serve as "designated patient representative": _____

Copy of documentation obtained for permanent record: □ Yes □ No

STATE OF HAWAI'I
CRIME VICTIM COMPENSATION COMMISSION
1136 Union Mall, Suite 600 / Honolulu, Hawai'i 96813
Telephone: (808) 587-1143 / Fax: (808) 587-1146

FORM #3

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

This Section should be completed by the **APPLICANT** and given to your **EMPLOYER** for completion.

I, _____, [DOB: _____, SSN: _____]
(Victim's First Name, M.I., Last Name)
authorize my employer, _____
_____
_____
(Full Name and Complete Mailing Address of Employer)
to release information to the Crime Victim Compensation Commission (CVCC) regarding my absence from work based on an incident which occurred on _____.

_____
Signature Date

After completing the top portion of this form, please give the form to your employer to complete and return to the Commission.

This Section should be completed by the **EMPLOYER** and returned to the **Crime Victim Compensation Commission.**

Employee's Job Title: _____.

The Employee was absent from _____ to _____ and returned to work on _____.

He/She was scheduled to work on (specify days/dates employee was scheduled to work during this period)

_____.

During the above period of absence, the employee **would have received** $_____ in gross earnings,

Based on $_____ per hour, _____ hours per day, _____ days per week.

Did the employee receive any of the following benefits?
(Please indicate gross amounts received. If **not eligible**, please indicate reason(s) for denial.)

Vacation Leave / Sick Pay $_____ Dates received for/Denial Reason: _____

Paid Holidays $_____ Dates received for/Denial Reason: _____

Temporary Disability $_____ Dates received for/Denial Reason: _____

Workers' Compensation $_____ Dates received for/Denial Reason: _____

Form Completed by: (Please PRINT or TYPE)

_____
(Name of Person Completing Form) (Title of Person Completing Form)
Signature _____

Telephone Number _____ Date Completed _____